(13)

No. 88-2043

In the Supreme Court of the United States

OCTOBER TERM, 1989

GERALD L. BALILES, ET AL., PETITIONERS

v.

THE VIRGINIA HOSPITAL ASSOCIATION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether a health care provider may bring an action under 42 U.S.C. 1983 to challenge a State's Medicaid plan on the ground that it fails to provide "reasonable and adequate" reimbursement, in purported violation of 42 U.S.C. 1396a(a)(13)(A) (1982 & Supp. III 1985).

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INTEREST OF THE UNITED STATES

Medicaid is a cooperative federal-state program "providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons" (*Harris* v. *McRae*, 448 U.S. 297, 301 (1980)). In developing plans for administering the Medicaid program, States are given considerable discretion in determining who will receive Medicaid assistance and what kinds of assistance will be provided. State Medicaid plans, however, must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. 42 U.S.C. 1396a (1982 & Supp. III 1985).

In this case the court of appeals held that an association of health care providers may bring an action under 42 U.S.C. 1983 to challenge a State's alleged failure to pro-

vide sufficient Medicaid reimbursement, in purported violation of 42 U.S.C. 1396a(a)(13)(A) (1982 & Supp. III 1985). The United States has a significant financial stake in the disposition of that issue. By law, the federal government provides between 50% and 83% of the cost of patient care, as determined by a formula keyed to per capita income of the State. See 42 U.S.C. 1396d(b) (1982 & Supp. III 1985). In fiscal year 1988 alone, the federal contribution to the Medicaid program for medical assistance totalled approximately $29 billion, making Medicaid one of the largest items in the federal budget.[1] Beyond this, the federal government makes at least a 50% contribution to the States' administrative expenses under the Medicaid program—including the cost of defending actions, like this one, for purported violations of the Social Security Act. See 42 U.S.C. 1396b(a)(7). In fiscal year 1988, the United States covered approximately $1.51 billion of state administrative costs.[2]

The United States also has a substantial interest in the particular legal question presented here. Regulations promulgated by the Secretary to implement the Medicaid statute require States to establish procedures that afford providers an opportunity to challenge reimbursement decisions. See 42 C.F.R. 447.253(c). Under the court of appeals' decision, however, state administrative procedures may be bypassed entirely, in favor of a federal court action under Section 1983. That result, if upheld, would have a significant impact on the Medicaid program. It would enable thousands of routine cases like this—involving a claim that a State

[1] Health Care Financing Admin., Dep't of Health and Human Services, *Medicaid Financial Management Report: Fiscal Year 1988* [hereinafter *Medicaid Financial Management Report*]. Of this sum, HHS provided $399.3 million to the State of Virginia.

[2] *Medicaid Financial Management Report*. Of this amount, some $25 million was provided to Virginia.

has failed to make adequate reimbursement to particular health care providers—to be brought in federal court. Such an explosion of litigation would vastly increase the cost of the Medicaid program, to the detriment of both state and federal governments, and to the ultimate detriment of Medicaid recipients.

STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Atkins* v. *Rivera*, 477 U.S. 154, 156 (1986); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36 (1981). As a cooperative federal-state program, Medicaid leaves the decision whether to participate to the sole discretion of each State. Once that initial decision has been made, States electing to participate must comply with basic requirements imposed by the Act and by the Secretary of Health and Human Services (see 42 U.S.C. 1396a (1982 & Supp. III 1985); *Rivera*, 477 U.S. at 157; *Gray Panthers*, 453 U.S. at 37). Within those basic limits, however, each State enjoys great flexibility both in administering its program and in deciding what specific provisions its program will contain.

To qualify for federal assistance, participating States must submit to the Secretary, and have approved, "a plan for medical assistance" (42 U.S.C. 1396a(a) (1982 & Supp. III 1985)). Among other things, such a plan must provide (42 U.S.C. 1396a(a)(13)(A) (1982 & Supp. III 1985)):

> for payment * * * of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State * * *) which the State finds, and makes

> assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access * * * to inpatient hospital services of adequate quality * * *.

The Secretary's regulations under this provision require the States to establish an administrative appeals procedure for providers to challenge Medicaid reimbursement decisions. In particular, the regulations mandate that States have an "appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the [state] agency determines appropriate, of payment rates." 42 C.F.R. 447.253(c).

In implementing Section 1396a(a)(13)(A), the Secretary has not provided a national definition or specific criteria for "reasonable and adequate" payment rates or for "efficiently and economically operated facilities." See 48 Fed. Reg. 56,046, 56,049 (1983). The Secretary has, instead, sought to preserve maximum flexibility for the States to respond to the particular and varied circumstances they face (*id.* at 56,048). Accordingly, the Secretary does not set "reasonable and adequate" rates; rather, as provided in the statute, participating States are required to submit assurances to the Secretary that *they* have made findings that their payment rates meet all statutory requirements. 42 C.F.R. 447.253(b)(2).[3] The States are not required to

[3] The regulations also require that before a State may seek the Secretary's approval of any significant changes in its methods and standards for setting payment rates, it must publish such changes for public comment, thus affording providers and other persons an opportunity to influence the rate-setting process. 42 C.F.R. 447.205, 447.253(f). In addition, in order to obtain the Secretary's approval of any change in payment rates, the State must submit an estimate of the average proposed rates for each type of provider, the difference between the proposed rates and the existing rates, and an estimate of the short-term and long-term effects of the proposed rates on the availability of services, the type of care furnished, the extent of provider participation, and the degree to which the proposed rates will cover provider costs in hospitals serving a disproportionate number of low income patients with special needs. 42 C.F.R. 447.255.

submit to the Secretary the findings themselves or the underlying data and analyses (see 48 Fed Reg. 56,046, 56,050 (1983)); instead, the Secretary examines the States' assurances to determine whether they are "satisfactory" within the meaning of Section 1396a(a)(13)(A). *Id.* at 56,050-56,051. The statute further provides that the States' assurances will be considered satisfactory, in the absence of a formal finding by the Secretary to the contrary. See 42 U.S.C. 1396a(b); 42 C.F.R. 447.256(b).[4]

2. a. The Commonwealth of Virginia has elected to participate in the Medicaid program. Accordingly, Virginia has submitted to the Secretary, and had approved, a plan for medical assistance pursuant to 42 U.S.C. 1396a(a) (1982 & Supp. III 1985). The plan categorizes hospitals into "peer groups," based on their size and location (urban or rural) (J.A. 25). For each group of hospitals, the Commonwealth in 1982 developed, on the basis of available cost data, a median cost of care per Medicaid patient day (*ibid.*). Hospitals were originally reimbursed at the median rate for their "peer group" or at their actual cost (plus a percentage of the difference between their actual cost and the median, as an incentive to stay below the median), whichever was

[4] The Secretary may request a State to provide additional background information if he believes it is necessary for a complete review of the State's assurances. 48 Fed. Reg. 56,046, 56,050 (1983).

lower (J.A. 25-26). Subsequently, the median rate became the payment ceiling for each group. Between 1982 and 1986, the ceilings were adjusted for inflation, using a modified national consumer price index (J.A. 12-13). Since 1986, the ceilings have been adjusted using an inflation index specifically based on medical care costs (J.A. 26).

Pursuant to federal requirements, the Virginia plan also creates an administrative appeals procedure for providers who wish to challenge Medicaid reimbursement decisions (J.A. 32-45). The procedure calls for an initial decision by Virginia's Department of Medical Assistance Services, informal review by a Department appeals officer, and a formal administrative hearing before a state hearing officer, who submits proposed findings of fact and conclusions of law to the Director of the Department of Medical Assistance Services (*ibid.*). Pursuant to the state Medicaid statute (Va. Code § 32.1-325.1 (Supp. 1989)), the Director's decision is thereafter reviewable in state court under provisions of the Virginia Administrative Process Act (*id.* § 9-6.14:1 *et seq.* (repl. 1989)). The Commonwealth's Medicaid appeals procedure precludes administrative review of the principles of Medicaid reimbursement under the state plan (J.A. 33), but there is no such specific limitation on the scope of judicial review in the state courts (see Va. Code § 9-6.14:17 (repl. 1989)).

b. Respondent is the Virginia Hospital Association, a trade association representing public and private hospitals in Virginia (J.A. 4-5). Respondent brough. this action under 42 U.S.C. 1983 to challenge Virginia's reir bursement rates under the state Medicaid plan. Respondent alleged that the plan systematically undercompensates providers for the costs of caring for Medicaid patients.[5] In addition, respondent

[5] In particular, respondent alleged that (1) the use of a general consumer price index to adjust reimbursement rates until 1986 resulted in an underestimation of the actual rate of inflation in medical care costs during that period; (2) even after the State adopted an inflation index based on medical care costs, it failed to apply the index properly; (3) adjustment of reimbursement rates solely by application of an inflation index, even one based specifically on medical care costs, failed to take into account other cost factors not related to inflation; and (4) the method of computing "peer group" medians failed to reflect the true impact of inflation on the cost of care, because variations in different hospitals' fiscal years resulted in the application of the inflation index to outdated cost data for many hospitals (J.A. 14-16).

alleged that the appeals procedure in the state plan provides an inadequate method for challenging defects in the Medicaid payment system because it excludes challenges to the principles of reimbursement and permits only case-by-case appeals involving the application of those rates to particular providers (J.A. 18-20). Respondent contended that the Virginia Medicaid plan violates 42 U.S.C. 1396a, as well as the providers' due process rights under the Fourteenth Amendment (Pet. App. A4). Respondent sought declaratory and injunctive relief, including an order requiring petitioners to promulgate a new state plan and, in the interim, to reimburse Medicaid providers "at a level commensurate with payment under Title XVIII of the Social Security Act, as amended, commonly known as the Medicare Act" (*ibid.*; J.A. 21-22).

3. After initially dismissing the complaint on collateral estoppel grounds (see Pet. App. A4), the district court, on remand from the court of appeals, denied petitioners' motion for summary judgment. The court held that Section 1396a(a)(13)(A) creates enforceable rights under 42 U.S.C. 1983, distinguishing this Court's decision in *Pennhurst State School & Hosp.* v. *Halderman*, 451 U.S. 1 (1981). Pet. App. D5.[6] The district court certified its decision for interlocutory review (*id.* at D1).

[6] The district court also held that the Eleventh Amendment does not bar relief in this case; that respondent has standing to bring the action;

4. The court of appeals affirmed (Pet. App. A1-A18), agreeing with the district court that Section 1396a(a)(13)(A) creates enforceable rights under 42 U.S.C. 1983. The court concluded that the language and legislative history of the Medicaid Act "reveal[ ] an unambiguous intent to assure reimbursement rates that are reasonable and adequate in fact" (*id.* at A7). The court explained that the various requirements for state Medicaid plans are "subject to the imperative of their predicate § 1396a(a), which indicates that the provisions specify what a State plan 'must' contain" (*ibid.*). That language, the court surmised, "reveals a congressional intent to condition federal assistance on states' achievement of the express purpose of the section, and not simply on states' assurances of compliance" (*id.* at A7-A8).[7]

The court of appeals held that the legislative history of the Medicaid Act confirms the availability of Section 1983 relief. Pet. App. A8-A10. The court explained (*id.* at A8) that certain Conference Committee remarks "make plain that the latitude § 1396a(a)(13)(A) grants States is not willfully to assign reimbursement rates, but flexibly to determine what methods and factors will produce rates adequate

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that the remedial scheme adopted by the Medicaid Act does not foreclose a Section 1983 remedy; that the statute of limitations does not bar the action; that the action is ripe for adjudication and is not barred by precedent; and that abstention by the court is unwarranted. Pet. App. D3-D8.

[7] The court acknowledged that the Secretary's regulations require him to review only the State's assurances that its methods and standards for setting payment rates are consistent with federal requirements. It also recognized that the regulations do not require federal review of the reasonableness of the actual reimbursement rates established under the State's plan. The court concluded, however, that those regulations – far from foreclosing a Section 1983 remedy – confirm that Section 1396a(a)(13)(A) was not intended to displace "federal judicial scrutiny" of the reasonableness of reimbursement rates. Pet. App. A8 n.4.

in fact given the circumstances particular to each State's hospitals." Moreover, the court stated, "[t]he legislative history * * * indicates that Congress intended no close scrutiny by the Secretary of Virginia's assurances of compliance with the mandates of § 1396a(a)(13)(A)" (*id.* at A9). Although the court acknowledged that "a logical reading" of this legislative history might be that Congress intended to "insulate[ ] State reimbursement programs from challenges by hospitals" (*ibid.*), it rejected that conclusion. Instead, the court inferred, the legislative record demonstrates that state review and assurances to the Secretary were not designed "to be the sole means of assuring that the Virginia system provides reasonable access to care of adequate quality" (*ibid.*).

Finally, the court of appeals held that the enforcement mechanism created by the Medicaid Act is not sufficiently comprehensive to foreclose recourse to Section 1983. Pet. App. A10-A12. The court recognized that, under the Act, the Secretary may review and audit the implementation of State plans, and that he may withdraw federal funds if necessary. The court also noted that various remedies are available under Virginia law to aggrieved Medicaid providers. Relying on this Court's decision in *Wright* v. *City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418 (1987), however, the court held that those remedies were insufficient to foreclose Section 1983 relief.[8]

SUMMARY OF ARGUMENT

The court of appeals has held that Medicaid providers may bring a Section 1983 action in federal court to challenge

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[8] The court of appeals also held that *stare decisis* and Eleventh Amendment principles do not foreclose the lawsuit; that respondent has standing to sue; that there is no statute of limitations bar; that the action is ripe; and that abstention is unwarranted. Pet. App. A12-A18.

a State's purported failure to comply with Section 1396a(a)(13)(A) of the Medicaid Act. In the court's view, Section 1396a(a)(13)(A) creates enforceable rights for purposes of Section 1983. Looking to the text and history of the Medicaid Act, the court concluded that Section 1396a(a)(13)(A) "reveals a congressional intent to condition federal assistance on states' achievement of the express purpose of the section, and not simply on states' assurances of compliance." Pet. App. A7-A8.

The text of the statute does not justify the court's conclusion. Far from creating the "specific and definite" rights afforded by the legislation at issue in *Wright* v. *City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 432 (1987), Section 1396a(a)(13)(A) simply requires States to include in their Medicaid plans provider payments "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *." As this Court explained in *Pennhurst State School & Hosp.* v. *Halderman*, 451 U.S. 1, 28 (1981), "[i]t is at least an open question whether an individual's interest in having a State provide those 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983." In any event, the statute by its terms does not require that rates be reasonable and adequate, and there accordingly can be no private right of action in federal court to secure such rates.

The legislative history of Section 1396a(a)(13)(A) confirms that Congress did not intend to create enforceable rights under Section 1983. Section 1396a(a)(13)(A) was amended in 1980, and again in 1981, expressly to free the States from the burdensome oversight of the federal government. It is difficult to believe that Congress—having deliberately insulated state administrative processes from superintendence

by the federal government—would permit the same close monitoring under the aegis of Section 1983 litigation.[9]

ARGUMENT

THE COURT OF APPEALS ERRED IN HOLDING THAT RESPONDENT MAY SUE THE COMMONWEALTH OF VIRGINIA UNDER SECTION 1983 FOR AN ALLEGED VIOLATION OF 42 U.S.C. 1396a(a)(13)(A)

A. There is no Section 1983 cause of action to enforce a federal statute unless Congress intended the statute to create enforceable rights

1. Under 42 U.S.C. 1983, any person who is deprived "of any rights, privileges, or immunities secured by the Constitution and laws" by a person acting under color of state law may bring a private action to seek redress. In *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in Section 1983 must be read literally, to create a private cause of action against state officials for violations of rights created by federal statutes. One year after its decision in *Thiboutot*, however, this Court in *Pennhurst* "recognized two exceptions to the application of § 1983 to statutory violations." *Middlesex County Sewerage Auth.* v. *Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981), citing *Pennhurst State School & Hosp.* v. *Halderman*, 451 U.S. 1 (1981). In particular, the Court held that a Section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under Section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; see also *Wright* v. *City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418 (1987).

The contours of the "enforceable rights" exception were laid out in *Pennhurst* itself. There, plaintiffs brought an action under the Developmentally Disabled Assistance and

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[9] The argument we present below is substantially similar to the argument we made as amicus curiae in *State of Oregon, Department of Human Resources* v. *Coos Bay Care Center*, No. 86-1419, vacated as moot, 108 S. Ct. 52 (1987). We have furnished the parties with copies of our brief in that case.

Bill of Rights Act, 42 U.S.C. 6000 *et seq.*, to challenge the conditions at a state-operated facility for the mentally retarded. Plaintiffs relied on several sections of the Act. The first of these, Section 6010 (the so-called "bill of rights" provision), set out a series of "findings respecting the rights of persons with developmental disabilities" (42 U.S.C. 6010 (quoted in 451 U.S. at 13)). The *Pennhurst* plaintiffs also relied on provisions of the statute in question that required participating States, as a condition of the receipt of federal funds, to make "assurances" to the Secretary that they had a habilitation plan in effect for the retarded (Section 6011) and that their programs protected their patients' human rights (Section 6063(b)(5)(C)).

Rejecting plaintiffs' claims, the Court in *Pennhurst* held, first, that Section 6010 "does not create substantive rights" and "does no more than express a congressional preference for certain kinds of treatment" (451 U.S. at 11, 19). Rather than imposing "binding obligations on the States," the Court explained, Section 6010 "spoke merely in precatory terms" and simply offered "congressional 'encouragement' of state programs" (451 U.S. at 18, 27). Turning to Sections 6011 and 6063(b)(5)(C) of the Act, which the courts below had not addressed, this Court remanded to the court of appeals for further consideration (451 U.S. at 30). But the Court noted that under those Sections plaintiffs "can only claim that the state plan has not provided adequate 'assurances' to the Secretary" (*id.* at 28). "It is at least an open question," the Court stated, "whether an individual's interest in having a State provide those 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983" (*ibid.*).

More recently, the Court applied the "enforceable rights" exception in *Wright* v. *City of Roanoke Redevelopment and Housing Auth.*, 479 U.S. 418 (1987). In that case, tenants living in housing projects owned by a city redevelopment authority brought suit under Section 1983, alleging that the

city had violated a rent ceiling imposed by the Brooke Amendment to the Housing Act of 1937, Pub. L. No. 91-152, § 213, 83 Stat. 389, and implementing HUD regulations. The Court held that the Brooke Amendment did create "enforceable rights," explaining that the Amendment "could not be clearer" in setting an upper limit on chargeable rents and in establishing "a mandatory limitation focusing on the individual family and its income" (479 U.S. at 430). The Court also stated that the standard set by the Amendment and its accompanying regulations was not "too vague and amorphous to confer on tenants an enforceable 'right,' " since the Amendment and regulations, taken together, "specifically set out guidelines that the [housing authorities] were to follow" (*id.* at 431-432). The Court accordingly determined that "the benefits Congress intended to confer on tenants are sufficiently specific and definite to qualify as enforceable rights under *Pennhurst* and § 1983" (479 U.S. at 432).

2. In deciding whether a federal statute creates "enforceable rights" under *Pennhurst*, a court must look beyond whether the plaintiffs are among the intended beneficiaries of the particular statute. A statute may intentionally benefit a particular person or class of persons, without creating "specific and definite" rights on their part (*Wright*, 479 U.S. at 432), and without designating them as the appropriate agents to enforce whatever rights exist. See Brown, *Pennhurst As A Source Of Defenses For State And Local Governments*, 31 Cath. U.L. Rev. 449, 459 (1982). As this Court has put it, "[t]he question is not simply who would benefit from the Act, but whether Congress intended to confer federal rights upon those beneficiaries" (*California* v. *Sierra Club*, 451 U.S. 287, 294 (1981)). In answering that question, a court must look, as this Court did in *Pennhurst* and *Wright*, to the language and history of the statute to discern whether Congress clearly intended to create a

"specific and definite" right and to authorize private enforcement of that right in federal court. Several principles should guide a court's approach.

First and foremost, the language of the statute must be mandatory and specific in order to create an enforceable right. As this Court has explained in a related context, the "right- or duty-creating language of the statute has generally been the most accurate indicator of the propriety of implication of a cause of action" (*Cannon* v. *University of Chicago*, 441 U.S. 677, 690 n.13 (1979)). The courts must therefore "distinguish statutory provisions that announce broad policy goals or general preferences from those that dictate specifically what the relevant governmental officials may and may not do" (*Edwards* v. *District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987)). Applying that distinction, "the courts of appeals in the aftermath of *Pennhurst* have, for the most part, upheld rights claims in statutes that dictate specific action and leave little room for choice, while rejecting rights claims in statutes that merely indicate broad preferences" (*ibid.*). This Court itself has explained that a statutory obligation must be "specific and definite" in order to create an enforceable right (*Wright*, 479 U.S. at 432), and the courts of appeals have similarly reasoned that the statute must be "cast in the imperative" (*Alexander* v. *Polk*, 750 F.2d 250, 259 (3d Cir. 1984)), and must "clearly impose[ ] an affirmative obligation" (*Polchowski* v. *Gorris*, 714 F.2d 749, 751 (7th Cir. 1983)).[10]

[10] The D.C. Circuit's decision in *Edwards* v. *District of Columbia*, *supra*, demonstrates, in our view, an appropriate consideration of statutory language in applying the "enforceable rights" exception. Plaintiffs there sued a local public housing agency for its alleged failure to comply with certain conditions imposed by federal law for the demolition of a federally funded housing project. Although the Secretary of HUD had not approved an application to demolish the project, plaintiffs asserted that the statutory conditions on demolition imposed independent duties on the local agency that tenants were entitled to enforce under Section 1983. The court of appeals rejected the claim and ordered dismissal of the complaint. Concluding that the federal housing statute did not create any enforceable rights, the court properly distinguished between "broad policy goals" and mandatory, right-creating provisions (821 F.2d at 656):

> While policy goals and general preferences leave much room for governmental officials to determine the means by which these goals and preferences are to be carried out, and therefore are ambiguous regarding what duties are owed to which citizens, specific language of obligation narrowly cabins the discretion of officials, and, by the same terms, secures rights to a specific class of people.

The court reviewed the language and legislative history of the statute and held that the obligations relied on by the plaintiffs were simply conditions precedent to the Secretary's grant of a demolition application; they did not create enforceable obligations independent of the application process.

Second, a court is to consider the nature of the federal standard imposed by the statute. Where, for example, the statute imposes an open-ended standard of "reasonableness," a court should be reluctant to conclude that Congress intended to authorize federal courts to superintend a State's compliance with that standard. See generally Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. Chi. L. Rev. 394, 428-430 (1982). Moreover, state administrative agencies, which deal on a day-to-day basis with the intricacies of their own grant programs, are obviously well suited to ascertain what is "reasonable" under all the circumstances, and that fact should make a federal court particularly reluctant to second-guess the State's assessment.

B. Section 1396a(a)(13)(A) was not designed to create enforceable rights for purposes of 42 U.S.C. 1983[11]

1. Section 1396a(a)(13)(A) does not read like a statute designed to "dictate specifically what the relevant governmental officials may and may not do" (*Edwards*, 821 F.2d at 656). Far from containing "right- or duty-creating language" (*Cannon* v. *University of Chicago*, 441 U.S. at 690 n.13), Section 1396a(a)(13)(A) permits participating States to devise reimbursement rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *." The statute further provides that such rates are to be set "in accordance with methods and standards developed by the State." By its terms, therefore, Section 1396a(a)(13)(A) vests ratemaking discretion in the States, subject only to the condition that they make "assurances" satisfactory to the Secretary. As this Court explained in *Pennhurst*, "[i]t is at least an open question whether an individual's interest in having a State provide * * * 'assurances' [to the Secretary] is a 'right secured' by the laws of the United States within the meaning of § 1983" (451 U.S. at 28).

Moreover, the standard of "reasonableness" set forth in the statute suggests that Congress did not intend the federal courts to monitor the States' compliance by way of private actions under Section 1983. This Court in *Wright* concluded that the Brooke Amendment and its implementing regulations created enforceable rights because they "specifically

[11] Because Section 1396a(a)(13)(A) does not create an enforceable right for purposes of 42 U.S.C. 1983, there is no need for this Court to reach the question whether Congress has created alternative remedies sufficient to foreclose enforcement through 42 U.S.C. 1983. See *Pennhurst*, 451 U.S. at 28; *Middlesex County Sewerage Auth.* v. *Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981).

set out guidelines that the [housing authorities] were to follow in establishing utility allowances" (479 U.S. at 431-432). Here, by contrast, Section 1396a(a)(13)(A) provides in general terms that the State must find, and assure the Secretary, only that its reimbursement rates are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws * * *." The implementing regulations reiterate that broad standard, leaving the States free to structure reimbursement systems tailored to their own objectives.[12] Nowhere in the statute can one find the "specific language of obligation [that] narrowly cabins the discretion of officials, and, by the same terms, secures rights to a specific class of people" (*Edwards*, 821 F.2d at 656). Rather, "[t]he subsection is essentially administrative in nature" (*Polchowski* v. *Gorris*, 714 F.2d at 751), entrusting to the individual States the duty to define and implement a "reasonable" reimbursement system.

The court below acknowledged that Section 1396a(a)(13)(A) "does not in so many words" require States to provide reimbursement rates that are, in fact, "reasonable and adequate." Pet. App. A7. It nonetheless divined in the statutory language "an unambiguous intent to assure reimbursement rates" that meet that standard. *Ibid*. The court reasoned that, pursuant to Section 1396a(a), a participating State "must" include certain designated elements in its plan, including the features required by Section 1396a(a)(13)(A). The court surmised that, by using the word "must," the

[12] Thus, 42 C.F.R. 447.252(a) provides simply that the state plan "must provide that the requirements of this subpart [implementing Section 1396a(a)(13)(A)] are met." 42 C.F.R. 447.253, which elaborates the requirements for "state assurances" under Section 1396a(a)(13)(A), merely requires state Medicaid agencies to "make * * * findings" that their Medicaid payment rates are "reasonable and adequate."

statute reflects a "congressional intent to condition federal assistance on states' *achievement* of the express purpose of the section, and not simply on states' *assurances* of compliance." *Id.* at A8 (emphasis added).

The language of the statute cannot be worked so hard. State plans "must," to be sure, contain each of the provisions listed in Section 1396a(a). But that "imperative" language (Pet. App. A7)—which may, *arguendo*, give rise to a lawsuit challenging a State's failure to include one of the designated provisions in its plan—has no bearing on respondent's lawsuit. Respondent does not assert that petitioners' plan is missing a term; it asserts, rather, that petitioners have not achieved "reasonable and adequate" rates, and it seeks an order requiring petitioners to pay such rates. Under the relevant statutory provision, however, no such "imperative" duty is imposed on the States. To the contrary, pursuant to Section 1396a(a)(13)(A), the state plan need only provide for payment "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate"—even if the rates that the State pays prove unsatisfactory to a Section 1983 plaintiff.

2. The legislative history of Section 1396a(a)(13)(A) confirms that Congress did not intend, as the court of appeals supposed (Pet. App. A8-A10), to create a right to "reasonable" reimbursement payments enforceable in federal court. To the contrary, the history of the statute reveals that Congress deliberately sought to avoid saddling state reimbursement decisions with cumbersome federal oversight. In view of that history, it cannot plausibly be contended that Congress expected private parties to enforce their own views of appropriate Medicaid rate-setting under the aegis of a Section 1983 action in federal court.

a. In 1972 Congress enacted a "reasonable cost" formula for making Medicaid reimbursements to skilled nursing facilities and intermediate care facilities. Codified at the time

in 42 U.S.C. 1396a(a)(13)(E) (Supp. II 1972), this statute required participating States to include in their Medicaid plans a provision "for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis." Social Security Amendments of 1972, Pub. L. No. 92-603, § 249(a), 86 Stat. 1426. That provision, linking reimbursement to facilities' actual costs, "was designed to assure that payment rates would more closely reflect the reasonable costs necessary to provide * * * services of adequate quality" (S. Rep. No. 471, 96th Cong., 1st Sess. 28 (1979)).

In 1979, however, Congress concluded that the "reasonable cost" reimbursement formula was no longer "entirely satisfactory" (S. Rep. No. 471, *supra*, at 28). Congress found that requiring States to adopt that formula had proved to be "inherently inflationary" and "contain[ed] no incentives for efficient performance" (*ibid.*). In 1980, therefore, Congress abandoned the "reasonable cost" reimbursement system and adopted the so-called Boren Amendment, now embodied in Section 1396a(a)(13)(A). Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2650-2651.[13]

The Boren Amendment "represented a significant change in the federal [reimbursement] standard," offering the States an opportunity to effect "more stringent cost containment" while freeing them from excessive "federal oversight of [their] reimbursement methodologies" (*Wisconsin Hospital Ass'n* v. *Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984)).

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[13] In 1981, Congress abandoned the "reasonable cost" reimbursement formula for hospitals as well, providing that hospitals, like nursing homes and intermediate care facilities, should be governed henceforth by a revised standard now incorporated in 42 U.S.C. 1396a(a)(13)(A). See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173(a), 95 Stat. 808. See generally *Wisconsin Hospital Ass'n* v. *Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984).

Congress chose to "give[ ] the States flexibility and discretion * * * to formulate their own methods and standards of payment" (S. Rep. No 471, *supra*, at 28-29).[14] By the same token, Congress intended that the degree of federal oversight should be significantly reduced. While pointing out that the Secretary would continue to insist on "assurances * * * that the payment rates * * * are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements" (*id.* at 29).

In enacting the Boren Amendment, therefore, Congress made clear that it did not envision rigorous federal scrutiny of the States' "assurances" under Section 1396a(a)(13)(A). To the contrary, Congress "expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary." S. Rep. No. 471, *supra*, at 29. See also 126 Cong. Rec. 17886 (1980) (Sen. Boren) ("[P]ayment methods adopted by the States will carry a presumption of compliance"). Indeed, the 1980 Conference Report stated that "[i]f, within 90 days of receiving the rates proposed to be used by a State, the Secretary has not made a final determination that the rates proposed meet all applicable requirements of medicaid law, then the rates would be presumed to meet the medicaid law requirements for the fiscal

[14] There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion on the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. See 126 Cong. Rec. 17885-17886 (1980). The Boren Amendment does not materially differ from the provision contained in the 1979 bill. See S. Rep. No. 471, *supra*, at 157-158. For that reason, we have set out in the text the relevant portions of the Senate report that accompanied the 1979 bill.

year for which they were imposed" (H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 154 (1980)). Consistently with this legislative history, the Secretary has maintained that Section 1396a(a)(13)(A) does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted. 48 Fed. Reg. 56,051 (1983).

The Boren Amendment, in short, was designed to promote two closely connected purposes. First, in order to reduce the cost of participating in the Medicaid program, the Amendment freed the States of the constraints previously imposed by the "reasonable cost" formula, and allowed state agencies "to establish rates on a statewide or other geographical basis, a class basis, or an institution-by-institution basis" (S. Rep. No. 471, *supra*, at 29). Second, the Amendment was intended to reduce the degree of federal oversight, on the theory that excessive federal scrutiny had "overburden[ed] the States and facilities with marginal but massive paperwork requirements" (*ibid.*).[15] In light of these purposes—carefully reflected in the plain language of

[15] In promulgating the regulations that implement Section 1396a(a)(13)(A), the Secretary reiterated in a preamble that the federal government should avoid excessive interference with the States' rate-setting authority under the Medicaid program. For example, several commenters had proposed during the notice and comment period that the Secretary "be more explicit as to [the federal] criteria for review of State assurances" (48 Fed. Reg. 56,050 (1983)). The Secretary rejected that suggestion (*ibid.*), finding that "such a list of criteria may be viewed as imposing Federal standards for repayment rates, an effect that would be contrary to the legislative intent." For the same reason, the Secretary rejected a proposal that the federal government define the term "efficiently and economically operated facility" as used in Section 1396a(a)(13)(A). See 48 Fed. Reg. 56,049 (1983). As the Secretary put it (*ibid.*), "we believe any Federal attempt to impose specific definitions would unnecessarily intrude upon the legislatively mandated flexibility provided to States under the statute."

Section 1396a(a)(13)(A)—it is difficult to imagine that Congress intended to authorize federal courts, in actions brought against the States under Section 1983, to develop and apply a federal common law respecting the "reasonableness" of particular Medicaid reimbursement rates.

b. The court of appeals took a different view of the legislative history of Section 1396a(a)(13)(A), but its conclusions cannot withstand analysis. Examining, first, the Joint Explanatory Statement of the Committee of Conference, the court observed that the Committee had stated "flatly" that it " 'intend[ed] that state hospital reimbursement policies should meet the costs that must be incurred by efficiently administered hospitals in providing covered care and services to medicaid eligibles' " (Pet. App. A8). The court, however, misconstrues those remarks. Read in context, the Conference Committee report simply explained that Congress had decided to jettison the "reasonable cost" reimbursement formula for hospitals, in favor of the more flexible standard previously adopted in the Boren Amendment for skilled nursing and intermediate care facilities. To accomplish that purpose, the 1981 legislation added hospitals to the list of facilities already covered by Section 1396a(a)(13)(A)—a provision which included the language at issue in this case: "which the State finds, and makes assurances satisfactory to the Secretary." There is no suggestion in the legislative history that Congress intended to confer on private parties an enforceable right to a "reasonable and adequate" rate schedule.

The court of appeals recognized that "[t]he legislative history * * * indicates that Congress intended no close scrutiny by the Secretary of Virginia's assurances of compliance with the mandates of § 1396a(a)(13)(A)." Pet. App. A9. And it acknowledged that one "logical reading" of that history is that Congress sought to "insulate[ ] State reimbursement programs from challenges by hospitals compensated at new, lower rates." *Ibid.* The court, however, drew the opposite conclusion: it surmised that Congress intended to "guarantee[ ] reasonable and adequate reimbursement to hospitals that achieve cost-efficiency." *Ibid.*

We believe that the "logical reading" offers a better account of the evidence: Congress did not intend to confer on Medicaid providers an "enforceable right" to challenge state reimbursement decisions in federal court. Lawsuits like respondent's interfere with state autonomy and discretion, and they contravene Congress's intent that the degree of federal oversight be minimized. There is no reason to believe that Congress wished the participating States to absorb the substantial costs entailed by such litigation.[16]

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[16] Four years prior to the Boren Amendment, Congress had amended the Social Security Act to repeal 42 U.S.C. 1396a(g) (Supp. V 1975), a provision that had required participating States to waive their Eleventh Amendment immunity from suits brought with respect to Medicaid payment for inpatient hospital services. Act of Oct. 18, 1976, Pub. L. No. 94-552, 90 Stat. 2540; see H.R. Rep. No. 1122, 94th Cong., 2d Sess. 1 (1976); S. Rep. 94-1240, 94th Cong., 2d Sess. 1 (1976). Congress repealed that provision, which had been enacted just the previous year, because it had "require[d] States to waive one of their basic rights" and had resulted in "an unreasonable burden of suits which [had been] costly in terms of time and legal manpower, and which [had made] efficient program administration virtually impossible" (H.R. Rep. No. 1122, *supra*, at 4). The House and Senate reports observed in passing that, after the repeal, "providers can continue * * * to institute suit for injunctive relief in State or Federal courts, as necessary." *Id.* at 7 (letter from Department of HEW); S. Rep. No. 1240, *supra*, at 4. Those remarks, however, cannot determine the availability of a Section 1983 cause of action under Section 1396a(a)(13)(A) as it now exists. As noted above (pages 18-22 & note 13, *supra*), Congress substantially revised that Section in 1980 and 1981 for the express purpose of conferring greater discretion upon the individual States in structuring their reimbursement systems, while at the same time reducing significantly the degree of federal oversight. Whatever federal remedies may have been available to Medicaid providers under the old "reasonable cost"

CONCLUSION

The judgment of the court of appeals should be reversed.
Respectfully submitted.

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reimbursement system, therefore, did not survive Congress's substantial revision of Section 1396a(a)(13)(A) in 1980.

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